Meeting:	**Grampian NHS Board Meeting**
Meeting date:	**7 October 2021**
Item Number:	**6**
Title:	**Primary Care**
Responsible Executive/Non-Executive:	**Simon Bokor-Ingram, HSCM Chief Officer**
Report Author:	**Sean Coady, Head of Service**

1 Purpose

1.1 This is presented to the Board for:

1.1.1 Assurance that Primary Care continues to meet the challenges of the COVID-19 pandemic, and in parallel will sustain development as a key component in the overall health and care system.

1.2 This report relates to a:

1.2.1 Continuing narrative on a national scale that Primary Care is not meeting the needs of our population. At a local level we need to be able to give assurance that Primary Care can continue to meet the needs of our residents. This aligns to the following NHS Scotland quality ambitions:

Safe - that services will operate within clear parameters and that care is joined up with other parts of the health and care system.

Effective - that the care and interventions provided are meeting national standards.

Person Centred - that we are listening to our residents and meeting their needs in the most appropriate way

2 Report summary

9 Services

10 Route to the meeting

11 Infrastructure

12 Information Management & Technology (IMT)

13 Recommendation

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3 Introduction

3.1 Primary Care is almost always a patient's first point of contact with NHS Grampian. It is estimated[1] that around 90% of NHS contacts take place within general practice. Primary care does not just comprise general practice. Community Pharmacy, Dental and Community Opticians also have a key role in providing care for patients in the community.

3.2 The purpose of this report is to inform the Board how Primary Care is continuing to operate in the current challenging environment due to COVID, and how it will continue to evolve and provide high value to our population.

3.3 General practice is experiencing challenges with the public perception of access to the service. There is a perception for some that general practice is closed. General practice has remained open throughout the pandemic, although we recommended from the start that practices only allowed entry on clinical grounds; this approach was in order to reduce the risk to both the public and to practice staff. The compliance with social distancing; use of personal protective equipment (PPE); and full risk assessments and alterations to buildings, are all measures that general practice took to protect patients and staff.

3.4 Whilst a number of appointments were already carried out virtually prior to COVID, this expanded to all initial assessments, where face to face appointments have always been available on the basis of clinical need. Increasing use of digital technology aided virtual appointments will become embedded in the way our practice clinicians interact with all patients in coming years, with phone consultations , Near Me, and Digital Asynchronous Consulting Services (DACS) giving increased ways of accessing health care. There are real benefits in embracing this change. Swifter access; more convenient for patients as avoids the need to travel to the surgery; and the use of DACS facilitates consultation at a time that is convenient to the patient. This also contributes to the carbon reduction agenda by reducing the need for unnecessary travel. The use of online medication ordering and booking services will also decrease waiting times for appointments by reducing the number of people who do not attend (DNA) their appointment.

[1] https://www.kingsfund.org.uk/sites/default/files/general-practice-in-england-overview-sarah-gregory-kings-fund-september-2009.pdf#page=2

3.5 Early survey reports indicate 71%[2] of patients are satisfied with DACS. We also should not solely use DACS as a barometer to measure the impact of all the changes, and are mindful of the challenges that change brings. We are working with the public engagement team to establish the needs of our local communities, and where there are gaps that translate to unmet need. A focus group will be established with public engagement support to look at the issues in more detail. Our Feedback Service are working closely with us to keep us updated of any issues to allow a real time solution focused approach and clear messaging within NHSG and general practice. Ultimately digital technologies offer the opportunity to capture the care needs of patients and then channel them to the right person, right time, and right place using the full Multi-Disciplinary Team (MDT). General practices have continued to offer health care on a needs basis throughout the pandemic and are embracing the changes to meet the demand moving forward.

4 The COVID response

4.1 All through the pandemic General Practice and Community Pharmacy remained open performing a vital role as first point of contact with the healthcare system. Both these contractor groups worked incredibly hard to ensure continuity of care, without the need to divert or close. This involved introducing measures to protect both staff and vulnerable patients to ensure they remained open. Dental and Optometry Primary Care initially operated emergency treatment centres for those in urgent need of treatment, with a phased return to services resuming in July 2020.

4.2 All primary care teams had begun a journey of transformation, with ‘right person, right place, right time’ aiming to deliver a better service to our population using “Homefirst” principles and ethos. Changes were being implemented following the 2018 GP Contract with the use of the wider primary care team and MDT, the pandemic has accelerated the implementation of these proposed changes and introduced some proposals that were in their infancy of thinking. This service change “in normal times”, would have been accompanied by extensive consultation with both patients and stakeholders. The pandemic has resulted in us making changes far quicker than we would normally.

4.3 Nonetheless, these changes have laid solid foundations for a model of Primary Care that is fit for purpose and reflects current healthcare needs and challenges. Some of the new models such as, phone triage, phone consultation, digital consulting, asynchronous consulting, first point of contact clinicians (physio, pharmacy, podiatry, optometry) have been embraced and this has allowed the GP role as expert medical generalist to manage the more complex health needs of many at this time. For some demographic groups this has proven more of a challenge and in recognition of this we are working closely with Patient Engagement and Corporate Communications to facilitate and encourage patient and whole system involvement in this journey.

[2] eConsult NHS Grampian patient activity survey November 2020

4.4 Throughout the pandemic Primary Care's response paralleled that of NHSG to ensure a whole system approach.

5 The Independent Contractor Model (ICM)

5.1 Virtually all Primary Care contractors operate as separate businesses in their own right, and are not directly employed by the NHS. Business types can be from a single handed practices, partnerships of varying size to large multiple Public Limited Companies. Each is governed by its own statute and regulations. Only General Practices hold a specific overarching contract to provide services, the other three groups are bound to provide the services stipulated in their regulations when listed to be entitled to provide clinical services in NHS Grampian.

5.2 General Practice

5.2.1 This operates under a General Medical Services contract with the Board. The majority of contracts are held by GP partnerships. There are 70 practices across Grampian, 3 of which are employed and run by NHS Grampian and 6 proposed to be run via 3 limited companies from autumn 2021. General practitioners inclusion on the Performer's List, and therefore eligibility to provide GMS services, is the responsibility of NHS Grampian. While some general practices are operated by an individual GP as a single handed practice, most are run by a GP partnership. This involves two or more GPs, sometimes with nurses, practice managers and others (as long as at least one partner is a GP), working together as business partners, pooling resources, such as buildings and staff, and together owning a stake in the practice business. GP partners are jointly responsible for meeting the requirements set out in the contract for their practice and share the income it provides.

5.2.2 The core parts of a general practice contract:

- An agreed geographical or population area the practice will cover
- Require the practice to maintain a list of patients for the area and sets out who this list covers and under what circumstances a patient might be removed from it
- The establishment of essential medical services a general practice must provide to its patients
- outline key policies including indemnity, complaints, liability, insurance, clinical governance and termination of the contract.

5.2.3 There are three different types of GP contract arrangements used by NHS in Scotland– General Medical Services (GMS) 17j, Personal Medical Services (PMS) 17c and 2c The 17j (GMS) contract is the national standard Scottish GP contract. This contract is negotiated nationally every year between NHS Scotland and the Scottish General Practice Committee of the BMA, the trade union representative of GPs in Scotland. The 17c contract is another form of core contract but unlike the GMS contract, it was negotiated and agreed locally by NHS boards with a general practice or practices. This contract offered an alternative route with flexibility to tailor requirements while also keeping within national guidelines and legislation. The 17c contract is being aligned to the 17j contract

reducing variation in services offered.

5.2.4 The 2C practice: The practice is run by the NHS Board. With effect from 1st April 2004, The Primary Medical Services (Scotland) Act 2004 amended The National Health Service (Scotland) Act 1978 by placing a duty on NHS Boards to provide or secure 'primary medical services' for their populations. NHS Boards can do so by making arrangements with 17C and/or 17J practices or can manage them under a 2c arrangement.

5.2.5 All types of contract are nationally managed by Scottish Primary Care division of Scottish Government. Where contracts are negotiated locally, Local Medical Committees (LMC) representing GPs participate in discussions and negotiations.

5.2.6 GP partners are not just clinicians but also small business owners and employers. This comes with a number of challenges, for example, the need to manage and optimise complicated income streams and personal liability for financial risks. It also means partners have a strong vested interest in maintaining and developing their practice.

5.2.7 Historically, the major levers for setting national or local priorities and implementing service improvements across general practice have been contractual, for example, the Quality and Outcomes Framework, now we are looking at clinical guidance to make the changes rather than contractual, although rapid transformation in the services GPs are providing in response to COVID-19 is challenging this assumption.

5.2.8 If local health systems are to achieve their full potential, a shared understanding of the differences between funding and contracting models for the different parts of that system will be important if partners are going to work effectively together.

5.2.9 GP practices are bound by the GP contract.

5.2.10 The Scottish General Medical Services (GMS) Contract (1 April 2018) is a joint agreement between the Scottish Government and the British Medical Association (BMA). The Contract sets out to:

- provide a new direction for general practice in Scotland which aims to
- improve access for patients, address health inequalities and improve population health including mental health
- provide financial stability for GPs, and reduce GP workload through the expansion of the primary care multidisciplinary team
- redefines the role of the GP as an expert medical generalist focusing on complex care, reduce the risks associated with becoming a GP partner and encourage new entrants to the profession as well as help retain existing GPs

5.3 Expert Medical Generalist (EMG) role

5.3.1 The Contract Offer set out a re-focussed role for the GP, working as part of an extended multidisciplinary team as an EMG: “This role builds on the core strengths and values of general practice-expertise in holistic, person-centred care-

and involves a focus on undifferentiated presentation, complex care including mental health presentations and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care."

5.3.2 General practitioners are contracted to perform essential (core) services and additional services although some are optional.

5.3.3 Essential services are mandatory for a practice to deliver to registered patients and temporary residents in its practice area. They include the identification and management of illnesses, providing health advice and referral to other services. GPs are required to provide their essential services during core hours, which are 8.00am–6.30pm Monday to Friday, excluding bank holidays. Local negotiation means that in Grampian core hours are 8 – 6pm. Out-of-hours services are those provided outside core working hours. A practice is assumed to provide these by default but can opt out. Where a practice opts out, as most practices do, NHS Boards have the responsibility for contracting a replacement service to cover the general practice area population: (Gmed services for NHSG).

5.3.4 Additional services: In addition to these core arrangements, a general practice contract also contains a number of optional additional agreements for services that a practice might enter into, usually in return for additional payment. These include the nationally negotiated Directed Enhanced Services (DES) that all Health Boards must offer to patients in their contract (Note that not all practices require to take out a DES as long as their patients can access that service if required) and the locally negotiated and set Local Enhanced Services (LES) that vary by area and practices can choose to sign up to these contracts.

5.3.5 These Enhanced Services are optional and coverage and take-up vary by practice across Grampian. This may be due to practice choice, local arrangements or, in the case of some enhanced services, lack of funding source identification. The Enhanced Service Group (see 5.1.3) meet regularly to ensure continued fitness for purpose. (Review of the enhanced services is underway at present) Activity data is shared with Health and Social Care Partnerships (HSCPs) and forms part of a practice's standard contract review meeting. Full details of the enhanced services on offer are detailed in Enhanced Services/Service Level Agreement packs, but they may be summarised as:

Directed Enhanced Services (DES)	**Local Enhanced Services (LES)**
Extended Hours Minor Surgery Palliative Care	Alcohol Brief Interventions Anticoagulant Monitoring Contraceptive Implants Diabetes Drugs Misuse High Risk Medication Monitoring IUCD Minor Injury Neo-natal checks Ring Shelf Pessary Care Homes

5.3.6 In addition to the 2018 GMS contract - The Memorandum of Understanding (MoU) is an agreement between the Scottish Government, the British Medical Association, Integration Authorities and NHS Board was agreed in April 2018. An updated version was issued in August 2021. The memorandum sets out the principles by which primary care redesign will be delivered.

5.3.7 Scottish Government is responsible for the negotiation of the GMS Contract and MoU with the Scottish General Practices Committee (SGPC) of the British Medical Association (BMA). Progress towards MoU and contract implementation is governed by the national GP Contract Oversight Group. HSCPs are asked to provide regular updates as to progress and resource commitment.

5.3.8 NHS Grampian is responsible for oversight of the progress towards contract delivery within HSCPs.

5.3.9 HSCPs have responsibility to ensure local contract delivery.

5.3.10 The development of primary care service redesign in the context of delivery of the new GMS contract should meet the following key principles: safe; person-centred; equitable; outcome focused; effective; sustainable; affordable.

5.4 Primary Care Improvement Plan (PCIP)

5.4.1 As a result of the MoU, all Integration Authorities now have locally-agreed Primary Care Improvement Plans (PCIP). Plans for 2019 to 2020 include local workforce planning, infrastructure development and patient engagement – work which will improve the primary care people receive in their communities. The PCIP covers 6 topic areas from the MoU:

5.4.2 Vaccination Transformation Programme

5.4.2.1 The Vaccination Transformation Programme can be divided into different work streams:

1. Pre-school programme

2. School based programme

3. Travel vaccinations and travel health advice

4. Influenza programme

5. At risk and age group programmes (shingles, pneumococcal, hepatitis B)

5.4.2.2 NHS Grampian has transferred all but 3 and 5 out of General Practice and is on track to transfer the remaining work streams by April 2022. Travel health services has been approved for transfer to community pharmacies from 1st October 2021.

5.4.3 Pharmacotherapy

5.4.3.1 Every practice will benefit from the pharmacotherapy service delivering the core elements as described below.

Level One (core)
Pharmacists: Authorising/actioning all acute prescribing requests Authorising/actioning all repeat prescribing requests Authorising/actioning hospital Immediate Discharge Letters Medicines reconciliation Medicine safety reviews/recalls Monitoring high risk medicines Non-clinical medication review Acute and repeat prescribing requests includes/authorising/actioning: Hospital outpatient requests Non-medicine prescriptions Instalment requests Serial prescriptions Pharmaceutical queries Medicine shortages Review of use of 'specials' and 'off-licence' requests
Pharmacy Technicians: Monitoring clinics Medication compliance reviews (patient's own home) Medication management advice and reviews (care homes) Formulary adherence Prescribing indicators and audits

5.4.4 Community Treatment and Care (CTAC) Services

5.4.4.1 Community treatment and care services include many non- GP services that patients may need, including (but not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection.

5.4.4.2 There was a 3 year transitional period that has been extended to April 2022 to allow the responsibility for providing these services to pass from GP practices to HSCPs. These services will be commissioned by HSCPs, and delivered in

collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

5.4.4.3 VTP, Pharmacotherapy and CTACS are a priority under MoU2 and HSCPs will be focussing on establishing them by April 2022. There will be financial transitional arrangements from HSCP to GPs if these services are not fully implemented by this date.

5.4.5 Urgent Care

5.4.5.1 Urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits.

5.4.5.2 This will involve the implementation of sustainable advance practitioner provision in HSCP areas, based on local service design. These practitioners will assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. Where service models are sufficiently developed, advanced practitioners will also directly support GPs expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes.

5.4.5.3 It is expected that the workload for advanced practitioners would mean that most GP practices would not have sole access to advanced practitioners. It is likely that advanced practitioners would work across a number of GP practices to meet patient needs. GP clusters will play an important role in enabling this service to ensure effective working and good patient outcomes.

5.4.6 Additional professional roles

5.4.6.1 Additional professional roles will provide services for groups of patients with specific needs that can be delivered by clinicians other than GPs, serving as first point of contact in the practice setting as part of the wider multi-disciplinary team. These include (but are not limited to) physiotherapy services, community mental health services and community links worker services.

5.4.6.2 HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the Primary Care Improvement Plan.

5.4.6.3 Community clinical mental health professionals (e.g. nurses, occupational therapists), based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

5.4.7 Community Links Workers (CLW)

5.4.7.1 HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support.

5.5 The Out of Hours (OOH) Service

5.5.1 Run by NHSG (Gmed), this is currently organised so the multidisciplinary team responds to the expected demand across the region. The service supports non-emergency, urgent health needs of patients across Grampian. The team is made up of General Practitioners, Advanced Nurse Practitioners and on occasion Paramedic Practitioners. Clinical teams are also supported by an operational and logistics team.

5.5.2 There are eight Primary Care OOH centres (Aberdeen, Stonehaven, Aboyne, Huntly, Inverurie, Turriff, Peterhead and Elgin). The service provides cover Monday to Friday between 18:00 – 08:00 and Saturday to Monday morning on a twenty-four hour basis.

5.6 Pharmacy

5.6.1 132 community pharmacies operate within NHS Grampian. Professional registration is via General Pharmaceutical Council and Contractor Support is via Community Pharmacy Scotland. The contract mix is between traditional businesses and large multiple groups e.g. Boots, Lloyds etc. No pharmacies are operated by NHS. Some elements of the business models are non-NHS e.g. shop retail. New pharmacy opening is governed and approved by the NHS Grampian Pharmacy Practice Committee. Pharmacies may elect to carry out additional services via numerous SLAs with NHS Grampian. These include:

National Core Services	Local Services
NHS Pharmacy First Scotland. Medicines Care and Review – including SOP for Serial prescriptions. Public Health Service – Emergency Hormonal Contraception and Sexual Health. Smoking Cessation Service. Gluten Free Foods Service. Poster Campaigns. Acute Medication Service. Unscheduled Care Service. Stoma Service. Waste Service.	Substance Misuse Service – Level 1. Naloxone Service – Training and Supply. Naloxone Service – Emergency Provision Compliance Aid Provision. MAR Provision For Care At Home Services. Hep C Service. Prostate Cancer Service. Buvidal Administration (Pilot). Care Home Waste Service. Palliative Care Network. Rota Service Provision. Public Holiday Service Provision. Substance Misuse Service – Injecting Equipment Provision. Travel Health Service Preferred Brand SLA.

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5.7 General dental services

5.7.1 92 independent contractors and three Public Dental Services with 22 clinical sites managed by the 3 HSCPS on behalf of NHS Grampian. All dentists are registered with NHS Grampian. Of the 92 independent, models range from partnership to large multiple groups. The actual NHS percentage of patients will vary at each practice. Traditionally NHS Grampian has had a low average NHS percentage, although there is evidence this is increasing slowly. There are also 4 wholly private practices in Grampian who operate out with the aegis of the NHS. Procedures covered under General Dental Services (GDS) are covered by the Statement of Dental Remunerations (SDR).

5.8 Optometry

5.8.1 56 independent contractors in Grampian, ranging from Independent Practices, Partnerships to large multiples. All Optometrists are registered with NHS Grampian. Some element of the optometry business model e.g. spectacles are not fully NHS funded and bring in non NHS income. NHS Grampian has a well-established Eye Health Network (EHN) which aims to enhance ophthalmic care in the community and maximise the use of the resource of community optometry. Local Enhanced Services are offered in addition including Co-Prescribing and Foreign Body Removal Using Sterile Needle and/or Alger Brush.

5.9 Quality / patient care

5.9.1 Quality in general practice is encouraged via the cluster model. GP clusters are typically groups of between five to eight GP practices in a close geographical location. As described in the Scottish Government's publication, 'Improving Together', the purpose of clusters is to encourage GPs to take part in quality improvement activity with their peers, and contribute to the oversight and development of their local healthcare system.

5.9.2 There is a nominated Practice Quality Lead in each GP practice and each cluster has a Cluster Quality Lead. Cluster Quality Leads support their local GP practices and liaise with locality teams and other professional groups and organisations.

5.9.3 The planning of GP Cluster quality improvement initiatives is informed by evidence and on population health needs, service capacity and demand and effective interventions to improve health and reduce inequalities. ISD Scotland holds a range of data supporting Primary Care, GP Clusters and Health and Social Care Partnerships to deliver high quality, effective and efficient services to meet the changing needs of the Scottish population.

5.10 The GP Cluster[3]

5.10.1 As senior clinicians, in their role as expert medical generalists where continuity of care and the longitudinal therapeutic relationship with patients remains important, GPs are ideally placed to be able to contribute effectively within a quality framework that is contextualised locally. The Scottish GMS contract will therefore facilitate and encourage some GPs to take on a greater role in the assessment and monitoring of quality within the systems in which they work as Practice Quality Leads and Cluster Quality Leads as part of the internal quality assurance of local services.

5.10.2 One GP from each practice (not necessarily always the same GP) will be the Practice Quality Lead (PQL) and have the responsibility as, and protected time to link with the Cluster Quality Lead. The Cluster Quality Lead is a GP nominated by the cluster with responsibility and protected time to provide a Continuous Quality Improvement leadership role in the GP cluster. The CQL will liaise between practices and the NHS board/Health and Social Care Partnership on quality improvement issues. The purpose of these clusters is to provide a mechanism whereby GPs may engage in peer-led quality improvement activity within and across practices and also contribute to the oversight and development of care within the wider healthcare system.

5.10.3 Aberdeen City HSCP have 4 GP clusters, Aberdeenshire 6 and Moray operate as 1 GP Cluster. The purpose of these cluster quality structures is to use data and health intelligence at a local level, cognisant of local priorities, to facilitate assurance and to drive improvement in the quality of care provided by different parts of the health and social care system. Where this assurance is not evident to HSCPs, further information may be requested from, clinical or management

[3] Improving Together Framework

teams, in line with the established purpose and principles of the Improving Together framework. A route of escalation within the local governance arrangements is provided via the clinical and care governance structure of the integrated authority,

5.10.4 The cluster quality leads have an important role in the GP cluster, in particular by demonstrating leadership in how discussions and activity here link to the wider clinical priorities, quality structures and to the locality management team. This allows optimal communication, analysis and discussion about all aspects of care within the locality and its linked community services and hospital(s).

5.10.5 Utilised in this way, each Health and Social Care Partnership may receive internal assurance about the care in each cluster, be made aware of any action plan necessary to address identified gaps, or influence resource necessary to address this.

5.10.6 Links between the cluster quality group and the locality management team will allow clinical risk associated with any perceived issues or problems to be managed, with a clear structure of escalation where this cannot be addressed at the locality level. In order that this is fully effective, there needs to be appropriate, open and transparent sharing of agreed datasets within these networks for public and patient benefit. It was hoped that the Scottish Primary Care Information Resource (SPIRE) may have produced these datasets but the final agreement on this has not been reached so other sources of agreed data are shared e.g. prescribing, e consult, lab test, referral and admission and enhanced services activity data.

5.11 Workforce

5.11.1 Recruitment and retention of GPs has been a long standing challenge for the North East with many vacancies across all areas despite excellent advertising (video) and incentives for this rural area (golden hello). GP staff can access Occupational Health NHSG services now but this has not always been the case.

5.12 Financial: Payment Models

5.12.1 General Practices

5.12.1.1 Paid via a nationally-agreed Global Sum, weighted for patient age, type and deprivation and locally agreed enhanced services contracts are paid in addition. Other payments may be received from additional locally agreed contracts i.e. community hospitals. In addition certain practice expenses may be reimbursable as a practice allowance. Administered payments refers to payments set out in the Statement of Financial Entitlements (SFE) . Payments in this category include, for example, locum allowances and appraisal costs.

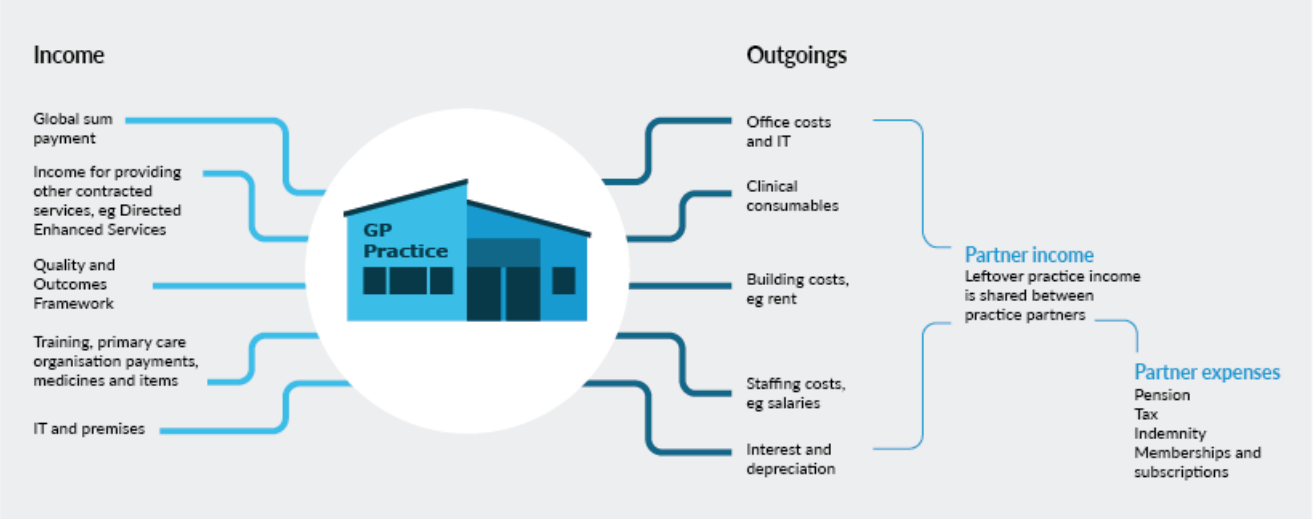
5.12.1.2 If a practice is leasing its premises, rent is generally reimbursed in full in arrears. If a partnership owns its premises, it is mortgage payments that are reimbursed through cost rent or notional rent schemes. Some practices sub-let rooms to other providers (for example community health services providers) but

there are rules on what a practice can use its building for, which affect reimbursement.

5.12.1.3 Premises are recognised as a particular burden and barrier to entry to new GPs entering the system, so the revised GMS Contract of 2018 set out ways to alleviate the premises burden, including sustainability loans for premises owners which can transfer ownership of premises from partnerships to health boards over a 25 year period and transferring responsibility for leasing premises from GP to health boards for those with 3rd party leases

5.12.2 What do GPs spend their money on?

5.12.2.1 Figure 1 Practice income, outgoings and partner share – English diagram (no Quality and outcomes framework in Scotland)



5.12.2.2 Paying its workforce – including salaried GPs, nurses, health care assistants and administrative staff – accounts for the majority of a practice's costs. These staff are usually employed directly by the GP practice and not by the NHS and so are not subject to Agenda for Change arrangements.

5.12.2.3 Partners pay themselves from the money that remains after other expenditure has been accounted for. Part of this personal income is used to pay their pension contributions, tax, indemnity, General Medical Council and other subscriptions. Partners may also decide to reinvest some of the remaining income into the practice. It is important to note that partners in GP practices are also personally liable for any losses made by the practice.

5.12.3 Pharmacy

5.12.3.1 Paid via item of service and local Service Level Agreements. Whilst there is a SLA contract pack issued annually, not all pharmacies opt take up all SLAs. As with GPs, certain practice allowances may be claimed.

5.12.4 Dental

5.12.4.1 Paid via item of service claims. There is an Enhanced Domiciliary Services Contracts for qualified independent dental contractors. Again certain practice allowances may be claimed.

5.12.4.2 During this pandemic, a financial support arrangement has been in place for dental practices based on their 'activity' levels. The activity measure used is the gross item of service which is the amount of fees claimed by the practices for the treatment provided. Practices are currently receiving 85 per cent of the income of the dental contractor's average monthly gross item of service income at the practice for the assessment period, 1 April 2019 to 31 March 2020. The average activity level in Grampian is currently 53% of pre-COVID levels based on this measure. However, some practices with little or no activity have continued to receive the financial support and the Chief Dental Officer has now written to NHS Boards to put in place improvement plans for practices below the 20% activity threshold to grow their activity levels beyond the 20% threshold.

5.12.4.3 There is a significant backlog of patients who need access to dental services and efforts are being made through the provision of ventilation system and dental equipment allowances to dental practices to improve capacity in general dental services. However, the current IPC measures and financial support arrangements present a challenging set of circumstances that make reductions in access to dentistry an ongoing risk for the Grampian population. The implications of the reduced access to dental services are the potential adverse impact on the affected population's oral health and the widening of existing oral health inequalities. Additionally, there is the increase in unscheduled dental care demand leading to pressures on the Emergency Dental Service and the Public Dental Service's capacity to meet the demand. This is likely to have a significant adverse impact on the ability of the PDS to deliver services to the vulnerable population especially as the service is already operating at reduced capacity.

5.12.5 Optometry

5.12.5.1 Paid via item of service claims. These GOS fees have been subjected to COVID top ups on an increasing item of service rate but end 1st September. Exceptions from practices could be submitted to HB for prior approval up to this time. Local enhanced services are offered and paid quarterly.

5.13 Risk assessment / management – governance arrangements

5.13.1 Clinical Governance

5.13.1.1 All 4 groups are bound by their professional bodies and associated regulation, and have the freedom to deliver services under those regulations in the manner that they deem appropriate. All contractors are subject to listing requirements before they may practice in Grampian. GPs require to complete annual

appraisal and 5 yearly revalidation under the General Medical Council (GMC) and NHS Grampian's Responsible Officer (RO) who has a role investigating any clinical issues.

5.13.1.2 Dentists are required under their Terms of Service to undertake 15 hours of Quality Improvement activities in a three year cycle. The General Dental Council also requires dentists to undertake 100 hours of verifiable CPD in a 5 year cycle and Dental Care Professionals such as dental nurses and dental technicians need to complete 50 hours of verifiable CPD in a 5 year cycle, whilst dental hygienists & therapists, orthodontic therapists and clinical dental technicians need to complete 75 hours of verifiable CPD.

5.13.1.3 To continue to be registered with the General Optical Council, Optometrists are required to submit 36 CET points over 8 competency types in a 3 year cycle. The current 3 year cycle ends in December 2021

5.13.2 Financial Governance

5.13.2.1 All transactions are carried out under auspices of NHSG standing Financial Instructions and Operational Scheme of Delegation and subject to annual audit within NHSG annual accounts.

5.13.2.2 Payment verification is carried out by NHS Grampian in order to ensure financial probity. This is carried out via a Partnership Arrangement with National Services Scotland Practitioner Services Division who carry out Payment verification on NHSG behalf in order to ensure financial probity.

5.13.2.3 Local contracts are reviewed by standing committees to ensure clinical efficacy, best value and performance.

5.13.3 Scottish Government

5.13.3.1 Have devolved responsibility from Westminster for healthcare, and associated legislation. Negotiates with professional bodies e.g. Scottish General Practitioners' Committee with respect to setting GMS Contract.

5.13.4 NHS Grampian

5.13.4.1 Holds the contracts for all contractors and sets strategic direction for Primary Care in partnership with IAs.

5.13.5 Integration Authorities

5.13.5.1 IJBs have responsibility for strategic planning and operational delivery of primary care.

5.14 Equality and Diversity, including Health inequalities

5.14.1 The responsibility for meeting equality and diversity lies with each independent contractor.

6 Activity data

6.1 Almost all General Practices in Grampian are independent businesses. Whilst they share the commonality of a General Medical Services contract with NHS Grampian, they have flexibility to deliver that in a manner that best suits their patient population. So one size definitely does not fit all and it then becomes difficult to establish a unifying metric or activity measure common across all that allows meaningful comparisons. Although at this time while a national agreed data set through SPIRE is finalised there are some local data sets available that reflect some of the activity of the practices.

6.2 Prescribing data has been available both to the HSCP, NHSG and the practices, this has helped improve prescribing. Data is also available via referral data, admission data, lab test data, out of hour's activity data and more recently asynchronous consulting and near me usage data

6.3 One area where there may be comparative data is in the use of digital asynchronous consulting (DACS). This is where information is submitted electronically, transferred to a practice leading to a response at a future point. NHS Grampian purchased a DACS product on behalf of General Practice during 2020 as part of response to the COVID pandemic and as a means to offer an alternative consultation model within the context of social distancing and infection prevention and control. Implementation began in summer 2020 and it is now operational across the majority of practices. Synchronous consulting e.g. face to face video consultations/NearMe was expanded at the same time.

6.4 Practices who were using DACS before 2020 have reported significant increases in activity numbers pre and post introduction of DACS. In total the number of DACS consultations has increased 5 fold across NHS Grampian since June 2020. NearMe consultations have decreased by a quarter over the past 4 months, although this time period is too short to draw meaningful conclusions.

6.5 Sample Primary Care Activity data for all contractors is included at Appendix 1.

7 Other impacts- complaints and feedback

7.1 All independent contractors are expected to operate their own complaints program. They are required to provide a summary of complaints to NHSG at least annually. Datix is only available to NHS sites and General Practitioners. In general terms feedback service does not become involved in these unless the nature of the complaint spans NHS Grampian e.g. where a complaint may have originated in primary care, and subsequently moved to secondary care.

7.2 If complaints remain unresolved they may be escalated to the Ombudsman.

7.3 For Optometry, any Datix cases are inputted by the HSCP Optometry Leads or the NHSG Optometry Lead and from there an investigation at the appropriate level is carried out in line with the GOS Adverse Events Policy.

8 Communication, involvement, engagement and consultation

8.1 NHS Grampian have been communicating with Scottish Government and NHSG Corporate Communications to ensure a consistent approach regarding public messaging across Primary Care, ensuring inclusion in the Remobilisation Plan and linking into the NHSG Community Engagement Group.

9 Services

9.1 How services are planned

9.1.1 Whilst the contractor's individual contract lies with NHS Grampian, the model they choose to deliver that contract is up to the individual contactor, providing they operate within the legislation. Models of care are frequently strategically driven nationally e.g. GMS Contract 2018 and associated Memorandum of Understanding for GPs, Oral Health Improvement Plan for Dental, Achieving Excellence in Pharmaceutical Care or Community Eyecare Services Review. HSCPs liaise with contractors and each HSCP has a strategic plan which independent contractors will be part of.

9.1.2 Services are underpinned by the principles of Realistic Medicine[4] i.e.

- Listening to understand patient's problems and preferences;
- Sharing decision making between healthcare professionals and their patients;
- Ensuring that patients have all the understandable information they need to make an informed choice;
- Moving away from the 'doctor knows best' culture to ensure a more equal partnership with people;
- Supporting healthcare professionals to be innovative, to pursue continuous quality improvement and to manage risk better;
- Reducing the harm and waste caused by both over-provision and under-provision of care;
- Identify and reduce unwarranted variation in clinical practices.

9.2 How services are accessed

9.2.1 Access to services is by patient request and at point of contact. Models of care will be different from contractor to contractor type. The impact of COVID has altered existing models of access with increasing reliance on virtual appointments e.g. NearMe to minimise nosocomial risk.

[4] https://www.realisticmedicine.scot/about/

9.2.2 During the pandemic there were difference approaches regarding patient access. Community Pharmacies remained the least changed, with all remaining open, but with limitations to the range of services provided.

9.2.3 General Practices all remained open, but access to walk in patients ceased with telephone triage in place to ensure those were seen as required by the most appropriate person in the way that met their healthcare needs. Many have appreciated the increased range of ways of accessing the most appropriate health care professional at first point of contract.

9.2.4 COVID patients were dealt with at dedicated COVID Hubs, which has managed to work as a totally remote service throughout much of the pandemic.

9.2.5 Both General Dental Services and Optometry were closed in the initial stages of the pandemic, with gradual reopening phased in from autumn 2020 and July 2020 respectively. For both these groups, urgent care and emergency appointments were provided by NHS Grampian via Public Dental Service or Emergency Eyecare Treatment Centres respectively.

9.2.6 Each contractor group's route to remobilisation was embedded in the NHSG Remobilisation plan and general practice in particular synchronised its readiness level to reflect that of NHS Grampian's overall escalation status e.g. Operation Snowdrop.

9.3 How services are managed

9.3.1 Primary Care is a hosted service, hosted by Moray HSCP on behalf of NHS Grampian. Moray also host GMED Out of Hours Service and both work in conjunction to provide consistent primary care services across Grampian.

9.3.2 Primary Care is governed by a committee and professional advisory structure that feeds into NHSG

9.3.3 Professional Advisory Groups

- GP Sub-Committee
- Area Dental Committee
- Area Optometric Committee
- Area Pharmaceutical Committee

9.3.4 These committees provide a professional advisory route to the board.

9.4 Standing Committees

- Primary Care Integrated Management Group
- Primary Care Operational Management Team
- Primary Care IM&T

- Premises Group
- Enhanced Services Group
- NHSG/LMC Negotiating Committee

9.4.1 These standing committees govern the strategic direction of travel for Primary Care, in line with national and local strategies.

9.4.2 Whilst the strategy is dealt with via the standing committees, Primary Care operationally is devolved locally to each HSCP with support from PCCT. This ensures that it fits within the local strategic context as well as allowing for operational aspects such as contract review and practice inspections. These also include review of the relevant mandatory Health & Safety requirements. Each HSCP has an overall clinical lead and clinical leads aligned to each contractor group.

9.5 Interface

9.5.1 The clinical interface group has been established to promote joint pathway development and review between primary and secondary care clinicians based on the Canterbury model. This is co-chaired by Clinical Director of Primary Care and David Lawrie, Divisional Clinical Director, Surgery reporting to Paul Bachoo, Portfolio Lead for Scheduled Care. This group has successfully developed pathways to improve the patient journey with understanding of the impact of these changes on the whole system and been able to overcome challenges which in the past would have prevented this progress. The group is supported by senior project management and Clinical and admin staff from Grampian Guidance.

9.5.2 There is also a regular weekly GP leads meeting, chaired by the Clinical Director of Primary Care, The group consists of Associate Medical Director, clinical leads for HSCPs, Clinical Director of Gmed, Head of Service and Service Manager, Primary Care Contracts.

9.5.3 This group, established during the pandemic has resulted in good communication, understanding the issues and formulating solutions that have often been shared across the 3 HSCPs. It has allowed good practice to be identified and shared. Communications and engagement officers are invited to join the group monthly along with PC managers to discuss the wider issues and formulate strategies of engaging and communicating with the wider health and social care service and public around access and present ways of working for primary care.

10 Route to the meeting

This paper has been co-produced with input from Chief Officers, Head of Service (Moray) for primary care contracting, Clinical Director Primary Care, Associate Medical Director Primary Care and Hosted Services, Director of Dentistry, NHSG Optometry Lead, Pharmaceutical Services Improvement & Development Manager and Service Manager Primary Care Contracts.

11 Infrastructure

11.1 NHS Grampian have a Primary Care Premises Group that work on prioritisation of capital programs, and work closely with each HSCP's premises function to ensure consistency of approach across NHS Grampian and alignment the NHSG Premises Plan 2021-31.

11.2 Premises Improvement Grants are on offer to all contractors and recent focus has been on delivering COVID infection control related works to all groups. In essence, the group's role is to:

- Monitor, and review the NHSG financial budgets for all Independent Contractor and Salaried Practitioners' premises developments to include General Practitioners, General Dental Practitioners, Pharmacists and Optometrists.

- Agree priority areas across Grampian for all Independent Contractor and Salaried Practitioners premises development proposals, assess the risks associated with projects and explore the various funding options that may be open to NHSG and Practices.

- Approve Option Appraisals and Business Cases for Premises Improvements, New Developments, and Temporary Accommodation all within the agreed priorities and/or funding agreed by the AMG.

- Score strategic assessments

- Make policy decisions for all Independent Contractor and Salaried Practitioners premises as required.

- Submit recommendations to the Asset Management Group as required.

11.3 In general, premises suitability remain a challenge. Estates have been incredibly supportive during COVID to bring practices up to a suitable Health & Safety level which was long overdue, including removal of carpets in all clinical areas, washable seating, reception screens, intercoms and ventilation systems. However there are still many old buildings with lack of space and not fit for purpose with no budget to invest in the future or lack of capacity for the MDT. There are the additional challenges of areas of increasing population and new builds with no ability within the present contract to form new practices or funding to expand practice buildings or develop branch surgeries.

12 Information Management & Technology (IMT)

12.1 Under the new contract, NHS Boards remain responsible for providing integrated IMT systems and telecommunications links within the NHS to General Practice.

12.2 NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland and was due to replace the present IT systems in 2020: this has been delayed.

12.3 NHSG has been proactive in providing appropriate IT systems and support to General Practice and have offered further equipment to help with the changing ways of working.

12.4 Primary Care IM&T Group acts as the overarching governance group for all contractors. The group ensures consistency with NHS Grampian eHealth and Digital strategies, along with encouraging the use of technological solutions to advance healthcare. Recent examples include NearMe and e-Consult asynchronous consultations.

12.5 The purpose of the Primary Care IM&T Group is for the planning, development, commissioning, support and maintenance of a fit for purpose IM&T environment across the General Practice that includes all salaried and independent contractors. The group will also play a key role in advising and developing an environment for all other contractors that is capable of communicating across the organisation.

12.6 The Primary Care IM&T Group will oversee the development and implementation of delivery plans around available funding on behalf of the Primary Care Integrated Management Group (PCIMG) and monitor all aspects of Primary Care IM&T/eHealth activities ensuring that all strategic objectives are achieved where affordable, and that patient care obtains the maximum benefit, while supporting clinical and integrated care.

12.7 The Primary Care IM&T Group will, on behalf of the NHS Grampian PCIMG, hold the following responsibilities for all aspects of Primary Care IM&T:

- Act as the custodian of the NHS Grampian Primary Care IM&T aspects of the eHealth Delivery Plan.
- Ensure delivery of the objectives within the Primary Care IM&T Local Development Plan (including the development of action plans, in partnership with HSCPs, in order to implement the agreed objectives.
- Undertake decision-making and stewardship with regard to Primary Care IM&T finance/resources.
- Provide the direct links to the HSCPs and Department of eHealth within NHS Grampian.
- To review progress against all priority investment programmes, ensuring that Business Cases are fully developed in line with national and local guidance.
- To assess and oversee training requirements for Primary Care, ensuring that user needs are met through the Learning and Knowledge ICT training and eLearning service where possible.
- To ensure that the PCIMG is kept informed regularly on Primary Care IM&T performance and delivery issues.

12.8 IT support level varies by contractor group. eHealth facilitators support practices and assist with access to NHSG Clinical systems, in conjunction with colleagues in Information Governance and IT Security. Only general practitioners have their IT system and the majority of IT equipment purchased and maintained. For other contractors the support is limited to eHealth facilitators.

13 Recommendation

13.1 The Board is asked to:

13.1.1 Note the high value primary care provides to the population of Grampian;

13.1.2 Support and promote the new ways of working throughout the organisation;

13.1.3 Note the important part the independent practitioners play in providing healthcare to the population of Grampian;

13.1.4 Note the unique position of general practitioners in providing continuous 24 hour health care to the population;

13.1.5 Note that general practice and community pharmacy has been reactive and delivered ongoing healthcare throughout the pandemic without the need to close any surgeries or pharmacies and with no additional help from other areas or departments.

13.1.6 Note the ongoing risk to access to dental services and that current measures to improve capacity might not be adequate to control the risk.

13.1.7 Note the ongoing work to engage with the public and recognise their needs, embracing the principles of realistic medicine. Whilst early in the stage of this journey we expect this may take place via patient focus groups or similar and will encourage clinical involvement in this process. We are actively engaging with Scottish Government around this to ensure consistency of governance and approach.

13.1.8 Review and scrutinise the information provided in this paper and confirm that it provides assurance that independent contractors are responsible for their own policies and procedures to meet the Health & Safety, HR and contractual arrangements

14 Appendix

14.1 The following appendix is included with this report:

Appendix 1 – Activity Data